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ABSTRACT

Provided for physicians and nurses is information on the diagnostic process and treatment programs for abused and neglected children and their families. An overview of the diagnostic and treatment process is outlined and general principles, such as the importance of early diagnosis, are discussed. The remainder of the book focuses on four phases: the emergency room or office phase, the diagnostic assessment phase, the acute treatment phase, and the long term treatment phase. Topics covered include the members and functions of a hospital or community-based child protection team, factors involved in the child abuse or neglect pattern, the special problem of failure to thrive, and the role of the juvenile courts. Long term treatment guidelines focus on five stages of the World of Abnormal Rearing cycle including unrealistic expectations of children and missed childhood. (LS)

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THE DIAGNOSTIC PROCESS AND TREATMENT PROGRAMS

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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Foreword

On January 31, 1974, the Child Abuse Prevention and Treatment Act (P.L. 93-247) was signed into law. The Act established for the first time within the Federal Government a National Center on Child Abuse and Neglect. Responsibility for the activities of the Center was assigned to the U.S. Department of Health, Education, and Welfare which, in turn, placed the Center within the Children's Bureau of the Office of Child Development.

The Center will provide national leadership by conducting studies on abuse and neglect, awarding demonstration and research grants to seek new ways of identifying, diagnosing and preventing this nationwide problem, and by giving grants to States to enable them to increase and improve their child protective services.

One of the key elements of any successful program is public awareness and understanding, as well as the provision of clear and practical guidance and counsel to those working in the field. It is for this reason that the National Center on Child Abuse and Neglect is publishing a series of six booklets—three comprehensive and related volumes describing the roles and responsibilities of professionals, and the community team approach among a wide range of other subjects; three shorter booklets will deal with the diagnosis of child abuse and neglect from a medical perspective, working with abusing parents from a psychiatric viewpoint, and setting up a central registry.

While some material in all these publications deals with studies of specific local programs as opposed to generalized approaches, they are not intended to represent categorical *models* upon which other programs should be based in order to be effective. Rather, they are intended to provoke thinking and consideration, offer suggestions and to stimulate ideas. Similarly, the views of the authors do not necessarily reflect the views of HEW.

We are deeply indebted to the six individuals who reviewed all these publications: Dr. Vincent DeFrancis, Mr. Phillip Dolinger, Ms. Elizabeth Elmer, Dr. Frederick Green, Dr. C. Henry Kempe and Dr. Eli Newberger. Their expertise and advice have been invaluable in putting this series together.

We hope that everyone concerned with detection, prevention and treatment of child abuse and neglect will find some, if not all, of these publications of use in the vital work in which they are engaged.

We hope, too, that they will be of use to those individuals and organizations wishing to become involved.

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Introduction

The purpose of this manual is to provide all physicians and nurses with the necessary background to understand the basic process in developing the diagnosis and the concept of treatment programs for abused and neglected children and their families. This material is not intended to be a "textbook" for the specialists in this vast area, be they physicians, social workers, judges, lawyers, law enforcement officers, school teachers, nurses or others.

While the author feels most strongly that these specialists *must* exist in every community or area with 150,000 or more population and that they must have a thorough understanding of this field, in excess of the information in this manual, those thousands of physicians and nurses who are not specialists in the area of child abuse and neglect but still work with family members (adults and children alike) need a basic understanding of this serious problem and what they and others can do about it.

This manual is put together in a manner that will allow the reader to understand the material at a rapid pace, with easy access to the information provided when a quick review is desired.

Beginning on page 6 the left hand page contains written material which is necessary for understanding the descriptive outline given in the display on the right hand page of the manual.

Some of the written material presented in this manual was originally published by Gerber in Pediatric Basics, Nos. 10 and 11, 1974 and is reprinted here with their permission.

Underlying Philosophy To This Diagnostic Therapeutic Approach

With most difficult problems which confront physicians and nurses in our day-to-day work the involvement of a wide spectrum of individuals is necessary if the patients' problems are to be clarified and a worthwhile treatment program implemented. Consider, for example, the 45-year-old male who has a sudden coronary and is near death. The most important people in this man's life are the personnel on the rescue squad, the emergency room staff, nurses and others in the cardiac intensive care unit, hospital technical staff; then the hospital ward nurses, home care and vocational rehabilitation planners, visiting nurses; and, of course, his doctor. The physician is lost without all of these disciplines readily available, each of whom are mutually dependent on the other.

Similarly, the successful assessment and treatment of a difficult case of child abuse or neglect requires a similar multidisciplinary group, each with specific (and somewhat overlapping) roles, and each interdependent on the other. As in the case of the coronary, if any of the disciplines begins to take on, or is given, responsibilities for which they are not prepared or trained, the program breaks down.

The social worker who is forced to make legal, medical and psychiatric decisions while being a police officer finds it difficult to function (and doesn't for any length of time).* Likewise, physicians who try to be a social worker or policeman generally find themselves well over their heads.

Helping the abused or neglected child and his/her family is very feasible in the great majority of cases but, like cardiology, takes the concentrated effort of a large number of individuals who mutually trust each other and have one common goal, i.e., a physically and emotionally healthier family.

While the author realizes that there are a host of ways to handle cases of suspected child abuse and/or neglect (and I have tried most of them over the years), what is presented here is a review of the way in which I approach these difficult problems, a system which has evolved over the years. This system works in the great majority of instances. There will, no doubt, be some who disagree with the approach. This is good; take what is useful, modify what needs modi-

* The turnover of protective service workers is approximately 30-50 percent per year in many cities. (See annual reports from Detroit, New York City and many other metropolitan areas.)

fication, and discard what isn't helpful (but substitute something which, for you and in your community, has been shown to work better). The goal is emotionally and physically healthy children and parents. Clearly there are a variety of means to this end, but those that I have tried, at least, do not work as well as the system described in this manual.

What Is Protective Services

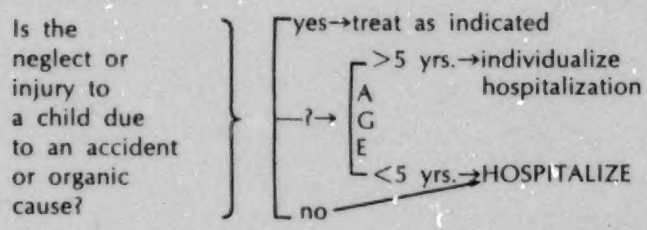
Throughout this manual the author refers to "Protective Services." This is the division of the local Department of Social Services whose workers specialize in the acute crisis intervention services for families in which child abuse and neglect is suspected. They may be referred to with different titles in various States, e.g. Child and Family Services, Child Welfare Division, etc. These social workers are truly a devoted group of people whose caseloads are much too large, emotional stresses too burdensome, backup support too little and rewards too scarce. There must be a very special place in heaven for these committed and beautiful people.

The physician should understand that their role is to perform short-term crisis intervention, child protection and *initial* family therapy. In most communities they are not sufficiently staffed to carry on long-term therapy, which of course is also necessary in most cases.

The Protective Services Division of your local Department of Social Services is the group to which the *mandated* report of all suspected cases of child abuse and/or neglect should be directed (by phone and then by letter). Some States require a report to go to the police as well, but generally the Protective Service Unit will take care of this aspect, if necessary. Their phone number should be readily available in your office.

The Diagnostic And Treatment Process
An Overview*

Emergency Room Or Office Phase
(see pp.8-9)



Diagnostic Assessment Phase
(see pp.10-21)

A. In consultation with community and/or hospital child protection team determine:

1. History
2. Physical
3. Laboratory
4. X-rays
5. Presence of potential
6. Special child
7. Crises

see pp. 10-17

B. At Case Conference Determine:

1. Problem list
2. Degree of safety of home
3. Treatment plan
4. Who is responsible for case coordination

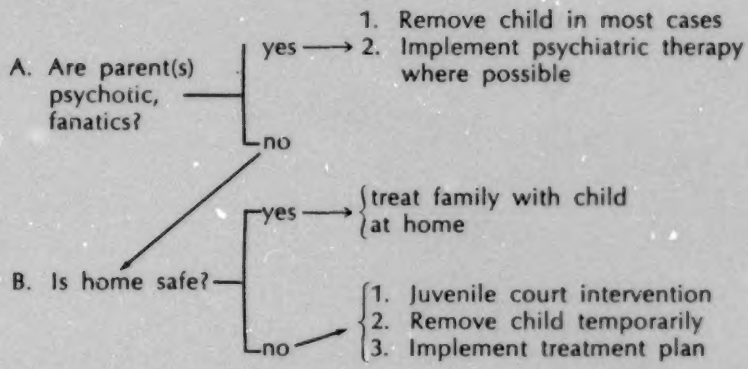
see pp. 18-21

C. Is Diagnosis Likely?

1. If no—discharge home if hospitalized or continue at home if not and arrange appropriate followup
2. If yes—proceed to next phase

* It is recommended that you refer to this overview frequently as you move through this manual.

Acute Treatment Phase
(see pp. 22-25)



Long-Term Treatment Phase*
(see pp. 26-43)

A. Are several approaches to treatment going on concurrently?

B. Is someone responsible for the coordination of these endeavors?

* The physician should be aware that long-term (many months or years) treatment and followup therapeutic services are rarely available within a given community, and that protective services is usually mandated to be a short-term (3-6 months) involvement and *not* a long-term program.

The Beginning

A Suspected Case is Seen and Handled Like Any Other Disease

You see a child in your office or in the emergency room who has the signs and symptoms of a disease. This disease carries a 3 to 4 percent mortality rate and a 25 to 30 percent permanent morbidity rate unless some specific treatment is initiated rather quickly. There is little question as to how one must proceed to make the diagnosis and initiate specific treatment as quickly as possible.

For some reason, however, physicians find it difficult to proceed in the accustomed manner when the problem they suspect is child abuse and/or neglect.

The fact that child abuse and/or neglect is a reportable problem does not seem to help the matter. In fact, making such a report often gives the physician the feeling that he no longer needs to be involved with either the diagnostic process or the treatment program. We physicians no longer can fail to give social service departments the assistance they need in making a definitive diagnosis of child abuse and/or neglect and the development of a treatment plan.

Many articles that deal with problems of abuse and neglect are accompanied by gruesome pictures of children who have been burned, beaten or in some way tortured. This, unfortunately, gives a very erroneous impression of the true nature of this problem. The diagnosis is not difficult when abuse reaches this level of severity. The challenge is to recognize the problem early in the pathogenesis so early treatment programs can be effective. In approximately 10 percent of all cases of children coming into an emergency room for treatment of an injury, the parents are unable to produce a logical explanation of how the injury occurred.

Physicians can ill afford to wait until the disease of child abuse and/or neglect becomes so severe that anyone could make the diagnosis. The state of our knowledge at this time gives us the ability to identify this problem earlier than ever before. In fact, we are moving toward the point where high risk families can be recognized prior to any physical insult to the child. This is not dissimilar to our present state of knowledge of cystic fibrosis, diabetes, and other familial diseases. Child abuse and neglect is indeed a familial problem and must be approached in the same logical, stepwise sequence used with all other serious problems that run in families.

Display #1
General Principles Of The Diagnostic Approach

1. Handle these cases like any other difficult diagnostic problems.
2. Do not forfeit the physician's responsibility
   a. Report all suspected cases of abuse and neglect to protective services.
   b. Support the protective service workers in the diagnostic assessment phase in planning and implementation of the treatment program.
3. Make diagnosis early; don't wait until the abuse and/or neglect has progressed so far that the effects are completely irreversible.

The Emergency Room Or Office Phase

Developing the Diagnosis and Initiating Treatment Can Rarely be Accomplished in This Setting

When the possibility of child abuse and/or neglect is suspected by the physician, he should proceed—in identical fashion—as if he were concerned about the possibility of an illness such as glomerulonephritis, cystic fibrosis, tuberculosis, etc.

In all child abuse and most cases of neglect, it is very uncommon to be able to develop the diagnosis, protect the child, and initiate a treatment program without the use of a short-term hospitalization. The child should be placed in the hospital whether or not the injury which the child has suffered is severe enough to require hospitalization. The decision as to whether the child should be hospitalized is based solely upon the degree of concern one has about the possibility of abuse and/or neglect, and the age of the child. It should be most unusual not to put a small child (under age 5) in the hospital for a diagnostic evaluation if the problem of child abuse and/or neglect is seriously considered.

The parents are encouraged to remain in the hospital with their child, 24 hours a day, if they can arrange their life accordingly. For those concerned about the emotional stress of hospitalization on a child the high mortality and permanent morbidity rate of this problem overrides this concern.

Most physicians will not find it difficult to convince the parents of the importance of hospitalization if they use the same technique used with any other serious illness. For example, if a child with anemia is found to have multiple bruises, many nodes and a large spleen, the child is admitted to the hospital for diagnostic workup and a treatment plan is developed. The parents are told that the child has an anemia or low blood and should be hospitalized. We do not tell the parents, "I think your child has leukemia and should be in the hospital." If on the other hand, the mother or father says, "Do you think my child has leukemia?" we should say in all honesty, "I really am not certain, and I know you're concerned. We will proceed to try to find out as quickly as possible."

If you are concerned about the possibility of child abuse and/or neglect, the same procedure works very well. Tell the parents that you truly do not know how the child got hurt and feel that you must do some studies, gather more

information, and work out a treatment plan. It is critical to say to the parents, "I know you are upset about this problem, and we will work out a plan that will be helpful to you." If the parents say, "Do you think I am beating my child?" your immediate reaction is to say, "I don't really know how your child has been hurt. You must be very upset. Let's bring him in and see what we can do to be helpful." This works over 90 percent of the time.*

The admission diagnosis should describe the physical findings such as fractured arm or multiple bruises, rather than "child abuse or Battered Child Syndrome."

When this plan is implemented within the community the protective service workers will often refer cases of physical abuse and serious neglect for admission and diagnostic assessment. When this occurs one gets the feeling that the community is beginning to work together.

Display #2

In the emergency room or office the physician and nurses should:

1. Be concerned about the diagnosis of non-accidental injury or finding of neglect. In at least 1 out of 10 children coming in with a history of being hurt, there will be difficulty determining the cause of the injury.
2. In all physically abused children and most cases of neglect in children 5 and under, regardless of the degree of injury, arrange for the child to be admitted to the hospital for diagnostic assessment and the initiation of early treatment for the child and his/her family. In children over 6, admission is often necessary but usually can be more individualized.

* Note: Some States allow the physician and/or hospital administrator to keep the child in the hospital (or admit the child from the emergency room) without the parents' consent. This action requires a court order on the "next court day." It is rarely necessary to use this law if the parents have been handled empathetically.

The Diagnostic Assessment Phase

A Multidisciplinary Diagnostic Team is Required

During this phase three questions must be answered: (1) Does the family situation meet the criteria for abuse to occur? (2) Is the home safe for the child? (3) How can it be made safer?

A Multidisciplinary Approach. At this point in the diagnostic process, the pediatrician and/or family physician should not try to be his own consultant. If you were to admit a child with suspected cardiac disease, often a life-threatening problem, it would be most common to seek consultation. The same is true with the problem of child abuse and/or neglect. Most practicing pediatricians, and family physicians neither have the time nor the experience to answer the three questions listed above.

There are specific bits of information that must be collected to determine if the criteria for diagnosis within a given family constellation are present. There are ways in which one can determine, with a reasonable amount of assurance, whether the home is safe, and, if not, what can be done to make it safe.

The gathering of these data requires the skills of multiple disciplines, including social work, nursing, psychiatry, psychology, pediatrics, and other specialists in this area. This concept is not dissimilar from the variety of specialists required to fully assess the child with congenital heart disease, cleft palate or meningomyelocele.

If a child abuse and neglect consultation team is not available in your community, it will be almost impossible to provide these sick families with all the up-to-date diagnostic treatment methods that are currently useful. Pediatricians and family physicians should demand such a program in their communities and become involved in the formulation of a diagnostic consultation team if one does not exist.*

* The American Academy of Pediatrics and the National Center for the Prevention of Child Abuse and Neglect in Denver have developed a series of self-instructional audiovisual units which will assist in the training of team members and provide a community or region with suggestions, and help in how to get started. Information about these units is available by writing directly to the author.

The primary physician must not be eliminated or bypassed as the diagnostic appraisal and plans for treatment are made. As with any other request for consultation, the primary physician must maintain his involvement over a long period of time. On occasion, if he wishes to turn the case over to another physician, this is certainly acceptable when one is available.

Display #3

The Hospital Or Community-Based Child Protection Team*

Consists of:

1. Protective Service Workers from Community
2. Hospital Social Worker
3. Pediatrician or Family Physician
4. Public Health Nurse
5. Psychologist or Psychiatrist
6. Lawyer
7. Law Enforcement Officer

One representative from each discipline

Plus

One **Salaried** Coordinator

* * * *

What do they do:

1. Meet regularly to discuss case referrals
2. Respond to consultations from physicians and others
3. Gather necessary data to make diagnosis
4. Support family throughout process
5. Collate data at case conferences
6. Recommend treatment plan
7. Followup on treatment plan

NOTE: These child protection teams function in the same manner as a cardiac diagnostic team does in assessing difficult cases and recommending a treatment plan.

*** An additional reference is "Development of Child Abuse and Neglect Community Programs" by Ray E. Helfer and Rebecca Schmidt. Contact authors for a pre-publication copy.**

The Diagnosis Should Proceed In An Orderly and Usual Fashion

Even though every primary physician should not be expected to become a specialist in the area of child abuse and/or neglect, it is helpful to have an overview of the basic process so he or she can become more aware and demanding of the consultants.

Drawing a comparison between our approach to a child with lead poisoning and that of child abuse may be helpful. When a physician is confronted with a child who demonstrates signs and symptoms of possible lead poisoning, some basic information may be helpful. For example, does his home meet the criteria for one who might have lead poisoning? Is there lead paint around, is plaster chipped off the walls, does the child eat this material, is the family such that they cannot or will not do anything about it? In brief, are the criteria present? Is the home safe? If not, what can we do to make it safe?

Our approach to the diagnosis and treatment programs of child abuse is no different. The primary physician, with his or her consultants, gathers the data necessary to determine whether the criteria for child abuse occur within the family.

The approach is, of course, not unlike the approach that we might use for making a diagnosis of glomerulonephritis. Are the criteria present for us to accept this diagnosis? Child abuse, like glomerulonephritis, has only one pathognomonic sign. In child abuse it is a confession; in glomerulonephritis it is the presence of red cell casts. There are many instances in cases of both problems that we must make the diagnosis without finding the pathognomonic sign. In fact, the relentless searching for a confession tends to initiate such anger on the part of the parents that treatment programs often are put in jeopardy.

The primary physician should insist that his consultants gather the data necessary to determine if the criteria exist. Secondly, he must insist that they give him some assessment about the safety of the home.

In addition, a complete diagnostic assessment must include photographs* if the injury or injuries can be seen on inspection of the child,* X-ray surveys, if there are indications that the trauma has been sufficient to cause bone injury, and a coagulation survey including a prothrombin

* Photographs are a necessary part of the child's record. Some States permit them to be taken without parents' consent. All States should.

time, partial thromboplastin time, bleeding time, platelet count, and tourniquet test. These latter are done, of course, if the child has multiple bruising and/or if the mother states that this child "bruises easily."

Display #4

Making The Diagnosis—A Comparison

The Diagnosis of SCAN* =	The Diagnosis of Lead Encephalopathy =
1. Physical findings** not explained by history	1. Convulsion without head injury, history of seizures, etc.
±	+
2. Laboratory data: specific for physical abuse and/or neglect	2. Red cell stippling and fragility changes, high blood lead level, etc.
±	±
3. X-ray changes***	3. Lead lines; plaster in abdomen
+	±
4. Child lives in family with potential (pp.14-17)	4. Child lives in lead environment
+	±
5. Special child— (pp.14-17)	5. Child with personality trait leading to pica
+	±
6. Crisis(es)— (pp.14-17)	6. Child develons colds, diarrhea, fever, etc.

NOTE: plus and minus for the two diseases vary

* SCAN = suspected child abuse and/or neglect.

** For a review of physical findings see:

a. James Weston, Chapter 4, The Pathology of Child Abuse. [In] THE BATTERED CHILD, 2nd ed., Edited by R. E. Helfer and C. H. Kempe, Univ. of Chicago Press, 1974. 262 pp. (p. 61–86).

b. Self Instructional Material by Barton Schmidt, Natl. Center for the Prevention of Child Abuse and Neglect, 1001 Jasmine, Denver, Colo. 80220.

c. Self Instructional Material by Medcom, Inc.

*** For a review of the Radiological findings see: Frederic Silverman, Chapter 3, Radiologic Aspects of the Battered Child Syndrome. Ibid (p. 41–60).

The Child Abusive and Neglecting Pattern

In order for a child to be physically injured or neglected by his parents or guardian several pieces of a complex puzzle must come together in a very special way. To date, we can identify at least three major criteria.

First, a parent (or parents) must have the *potential to abuse*. This potential is acquired over the years and is made up of at least five factors:

1. The way the parents themselves were reared, i.e., did they receive a positive "mothering imprint?"
2. Have they become very isolated individuals who cannot trust or use others?
3. Do they have a spouse that is so passive he or she cannot give?
4. Presence of a poor self image.
5. Do they have very unrealistic expectations of their child (or children)?

Second, there must be a child. As obvious as that might sound we point it out because this is not just *any* child, but a very special child. One who is seen differently by his parents; one who fails to respond in the expected manner; or possibly one who really is different (retarded, too smart, hyperactive, or has a birth defect). Most families, in which there are several children, can readily point out which child would have "gotten it" if the parents had the potential. Often a perfectly normal child is "seen" as bad, willful, stubborn, demanding, spoiled or slow.

Finally, there must be some form of crisis, or a series of crises, that sets the abusive act into motion. These can be minor or major crises—a washing maching breaking down, a lost job, a husband leaving, no heat, no food, a mother-in-law's visit and the like. It is most unlikely for the crisis to be *the* cause for the abuse, as some would like to believe; rather the crisis is the precipitating factor. The simplistic view that child abuse is caused by parents who "don't know their strength" while disciplining their child has been shown to be false.

It is this combination of events that, when they occur in the right order and at the right point in time, lead to physical abuse.

Display #5

In order for a small child to be abused or neglected, at least three things must occur or be present:

A. *The presence of the potential within the family:*
   1. Parents reared in a traumatic (physically or emotionally) manner
   2. Parent(s) who are isolated and distrustful
   3. Spouse who gives little bailing out
   4. Poor self image by parent(s)
   5. Unrealistic expectations of children

Plus

B. *The presence of a special child who:*
   1. Is seen as different and/or
   2. Really is different

Plus

C. *The presence of a crisis or crises which are:*
   1. Physical—i.e., no food, money, heat, lights and/or
   2. Personal—i.e., death, separation, etc.

NOTE: These areas are discussed again in more detail later in this manual under the World of Abnormal Rearing (pp.26-37).

The Special Problem of Failure to Thrive (F.T.T.)

For the purpose of this manual, F.T.T. is defined as any infant (generally less than 1 year of age) who fails to grow (in height and weight) and develop (in personal-social, adaptive, language and/or fine and gross motor areas) as compared to pre-established standards over a period of time (generally a few weeks). These standards are the usual growth grids and developmental criteria, such as the Denver Developmental Screening Test.

The cause of this common problem can be divided into four areas which make up the great majority of the cases plus one miscellaneous group. The four are those problems associated with the central nervous system (CNS), parenting, the renal and cardiac systems. Together, these appear to make up over 80 percent of the cases of F.T.T.

The diagnostic assessment of these babies and their families should proceed, as with all other medical problems, along a very orderly and planned fashion. Most of the problems with the heart, kidneys or CNS that cause F.T.T. are of the nature that their diagnosis is not difficult with the help of a complete history, physical, and a few well planned laboratory studies. These can be done either in the office or during the first 48 hours after hospitalization.

All of these babies must be hospitalized (as with physical abuse) and no more than 2 days given to evaluating the three major organic causes. Then a full 7-10 days *must* be allocated to the problem of minimal mothering.* This is accomplished by intense nurturing of the baby by people assigned specifically to this task. During this period, careful observation and measurements are made both in growth and development. A large portion of these babies (possibly as many as two-thirds) will thrive with this plan.**

---

* The term mothering is used as a verb, to mother, meaning nuturing, caring for, to pick up, talk to, feed, smile at, cuddle, rock, etc. Mothering can be done by a variety of people, the mother being one, and in our culture the most important person in the new baby's life. The term "parenting" is proposed by some.

** The reader is referred to the work of Marshall K. Klaus, M.D., John Kennell, M.D. and others regarding early mother-baby attachment.
Klaus, M. and Kennell, J. "Mothers Separated From Their Newborn Infants," *Ped. Cl. of N.A.*, 17:1015, 1970.
Klaus, M. and Kennell, J. "Followup of Low Birth Weight Infants—the Reduction Value of Maternal Visiting Patterns," *Ped.*, 49:287, 1972.

If they do, of course, the child protection team must be consulted, the parents worked with intensely during the whole process. If they do not then, and only then, can the diagnostic assessment move to the more exotic and uncommon.

Display #6

Failure To Thrive: babies who do not grow or develop over a period of time

This is due to:

Problems with:

1. Mothering
2. Heart
3. Kidneys
4. Central Nervous System

in approximately 80 percent of the cases (or more). In 20 percent (or less) a more exotic and rare cause may be identified.

The Diagnostic Assessment is as follows:

1. Hospitalize the babies.
2. The first 48 hours is used for easily performed studies and examinations relating to the heart, kidneys and CNS.
3. During the next 7-10 days, a defined nurturing plan for the baby is implemented, using specifically assigned personnel and the mother.
4. If problems of mothering are the cause (i.e., the baby grows and develops with nurturing) the child protection team should be consulted, as early in the hospitalization as possible.

A Review and Planning Conference is Mandatory

It will become readily apparent, as the diagnostic process proceeds, that the data necessary to make the diagnosis of child abuse and/or neglect come from many different sources, i.e., the physician's observations, the nursery school teacher, nurses' observations, laboratory, X-ray, social workers, psychiatric assessment, etc. As in the case for other serious complex diagnostic problems, a "meeting of the minds" is necessary if all the data are to be reviewed and a reasonable decision about treatment is to be generated.

Consequently, a conference must be held. The participants are those who have bits and pieces of information that will contribute to the whole. There is no way of avoiding this conference in a case of child abuse and/or neglect any more than avoiding a conference on a child with meningomyelocele who requires the services of six to seven different disciplines. Each of the individuals involved should know the others' thinking, as well as the total plan if he or she is to be effective.

The pediatrician or family physician must not be satisfied with consultants who do not go through and include him in the above diagnostic procedures in careful, step by step fashion. He must be demanding and, if these services are not available in his community, someone in the community must see that they are developed.*

Early in the diagnostic assessment, those parents who fall into the severely ill, psychiatric categories (such as psychosis) must be identified. It is critically important to have a skilled interviewer (psychologist, psychiatric social worker and/or psychiatrist) make this assessment. In one out of ten of the families, one or more parent falls into these categories. Generally speaking, they can be suspected when premeditated abuse has occurred, repetitive torture is present, or the parents do not "fit" the criteria delineated above.

Treatment programs that are required for psychotic parents are different from those that will be described in the next section. Psychotic parents must be identified and

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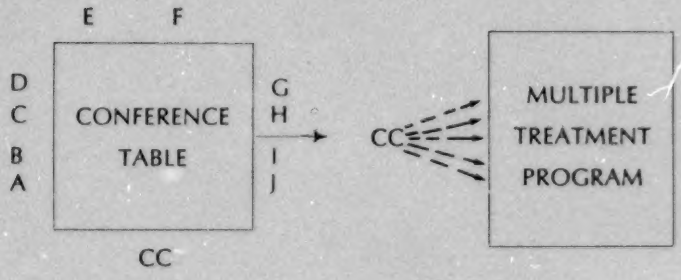
*One of the self-instructional audiovisual units mentioned earlier is on the development of community programs. This should be helpful if a multidisciplinary committee wishes to initiate such a service in a community (Unit V).

helped as much as possible.** The recommendations provided to those in authority (i.e., courts) may well be different in these situations from those in the more classic form of abusive parents.

Display #7

The Case Conference Review Must Be Held Within 3-4 Days After Case Recognized



CC = Case Coordinator (usually the Protective Service Worker)

Disciplines A, B, C, etc., share data gathered; also in attendance is primary physician for family.

* * * *

The following are accomplished:

1. Problems are listed
2. Home-Safe Checklist is completed (see pp. 21)
3. Plans for treatment are made
4. Responsibilities are delegated
5. Long-term coordinator is clarified

** It is my impression that psychotic parents rarely rear children in an acceptable manner. The reader may wish to refer to another booklet in this series, WORKING WITH ABUSIVE PARENTS FROM A PSYCHIATRIC POINT OF VIEW, published by OCD.

The Home-Safe Checklist Must Be Completed at the Case Conference

Once the diagnostic process has been completed and an assessment of the total situation made, the primary physician and his consultants (i.e., the Child Protection Team) will have formulated a good assessment as to the safety of the home in question. A determination must be made as to how much time and effort is required in treatment to make an unsafe home safe.

Going back to our example of lead poisoning, when we find that a home is unsafe for a child's return, we must in some way modify that home. On occasion it is necessary to move the whole family into another setting. Regardless of how it is resolved, we must not send children back to the environment where the initial problem occurred until we have modified that environment to assure, as much as possible, the safety of the child. This approach does not change when the diagnosis is child abuse and/or neglect.

Not uncommonly it is determined that a home is not the appropriate place for the child in question. The diagnostic team may decide that, by all available estimates, it may take time (3 to 9 months) to get the home to a level of safety they are willing to accept. The concept is quite familiar to pediatricians who constantly make these judgments in determining whether a child should or should not be in the hospital.

For example, we often place children with pneumonia in hospitals when we feel that the parents cannot care for the child in the manner that is appropriate under the circumstances. We then wait for the child to reach a point in the disease process when the parents can take over the care in the home once again. There is no difference in the philosophy used with pneumonia as compared to child abuse and/or neglect. We must get the family to the point where they can handle the child without running the risk of either neglecting or physically abusing him.

* Note: See pages 24-25 regarding use of Juvenile Court.

Display #8

How Safe Is The Home Checklist

A. Physical findings:

1. Are they explained by history?
2. Do they represent non-accidental injury or neglect?
3. Did child thrive in the hospital?

B. How does each parent see:

1. His/her rearing?
2. His/her parents now?
3. Others?
4. Themselves?
5. Their spouse?
6. Children in general?
7. Child in question?
8. Child's siblings?

C. How are crises handled by the parents:

1. Emotionally (personal problem)?
2. Logistically (transportation, finances, food, etc.)?

D. Do the parents:

1. Know much about child rearing?
2. Know the skills of caring for a baby?
3. Know anything about child development?

The Acute (1st Three Months) Treatment Phase

Treatment must begin before the diagnosis is finalized. Parents who have the potential to abuse and/or neglect their children are frightened, distrustful, angry people. Consequently, they will be suspicious of any attempts to become involved. Ambivalence is great, in that they do not want to beat their children, and they are anxious for someone to say, "We will help you." But they trust few people, if anyone.

They cannot trust you enough to become involved. They move from hospital to hospital not so much because they are afraid someone will find out what is happening; rather they keep shopping until someone does find out. They get angry if you keep after them to become involved and, if you do not keep after them, their anger gets worse.

This is a most confusing aspect of this problem. The physician and others who are trying to be helpful are placed in a difficult situation. You are truly "damned if you do, and damned if you don't." It is more comfortable to avoid the problem and say, "Well, if they aren't motivated, we don't need to bother with them." And yet we have to face up to the fact that approximately 1,500 children each year are dying from this problem, and approximately 15,000 are becoming permanently brain damaged while nothing is being done for them.

The initiation of treatment, therefore, must begin as soon as one has any reasonable suspicion about this diagnosis. This is done by placing emphasis on the parents and not just on the child. Statements such as "You must be upset," or "It's O.K. to get angry," or "Let's see what we can do to help *you*," etc., are helpful.

Pediatricians frequently avoid their own feelings in these difficult situations by talking to the parents only about their child: "His X-rays are normal or abnormal," "His bruises are better," "His fracture is healing," "He's doing all right," etc. We frequently fail to ask parents how they are doing. Appointments must be made with the parents to see the pediatrician without the child. They should be given the clear impression that they do not have to have an injured or sick child in order for them to see the doctor. They indeed can call or come in when *they* are upset.

Treatment is beginning throughout the whole diagnostic process. The parents must be kept informed in a painstaking manner. They must be told the truth, but with reasonable judgment to make sure they are not being told more

than they can accept at any point. When the time comes for the physician to make his report, which is required by law in *all* suspected cases of non-accidental injury, the parents must be told the report is going to happen.

I tell the parents that, as a practicing physician, I must send in a report on all child injuries when the cause is not clear. Then I explain the contents of the report, to whom it is sent and what will happen after the report is received. Since it is unlikely the primary physician actually will know what will happen when the report is received, members of the diagnostic consultation team should work with the parents around this issue.

Many teams actually make the report. This is just as appropriate as having the cardiologist consultant explain to the parents what's going to happen in the cardiac catheterization room, or in the operating room. The primary physician should not be put in a position of explaining something to the parents about which he knows little.

Display #9

A. Treatment begins as soon as diagnosis is strongly suspected
   1. Physician and nurses must be honest and empathetic with parents.
   2. Involve Child Protection Team consultants early

B. Coordination of Acute Treatment Phase
   1. In 1st few days this is the role of hospital social worker until report made
   2. Gradual transition to protective services worker

C. Long-term Treatment (see p. 26)
   1. Start as soon as feasible
   2. Coordination of this phase transmitted from protective service worker to ? . (see p. 42)

The Juvenile Court Can Be Helpful

When removal from home is necessary in the case of child abuse and/or neglect, it is almost always mandatory to use the Juvenile or Family Courts. The court should be seen as helpful. The question to ask is, "Can the court be helpful in this case?"; *not* "Do we have enough evidence to go to court?" The Family Court is not trying to adjudicate guilt, rather determine whether the child has been injured or neglected and, if so, what can be done to help the family (i.e., make the home safe).

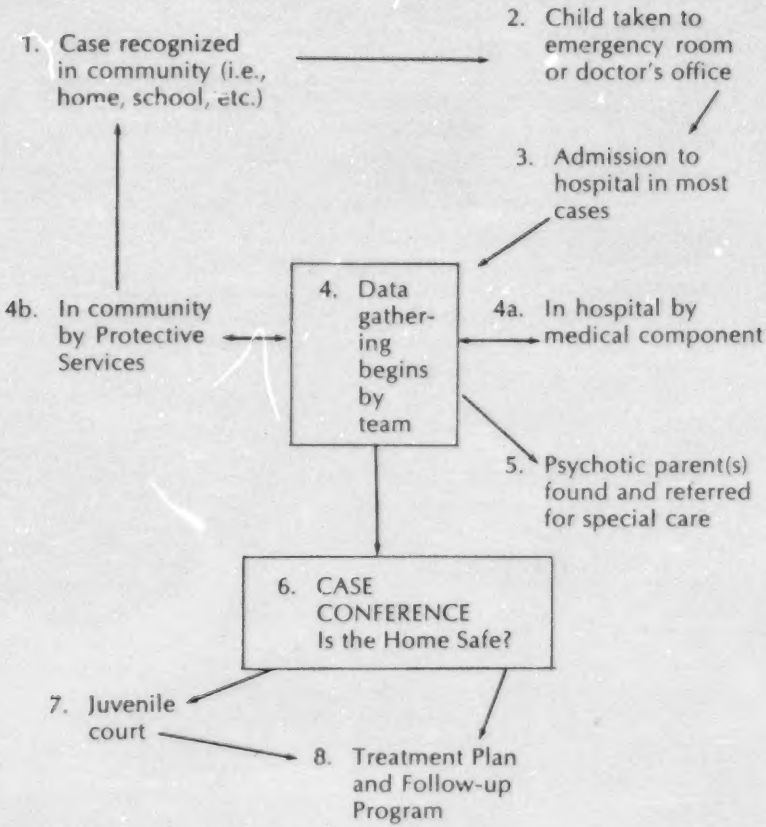
The involvement of the court is related directly to the assessment of the safety of the home. If the home is unsafe and time is required to make necessary changes, and if this time extends beyond a few days, then the court should be involved. In our experience it would seem likely that the courts will be involved in about 30 percent of cases of physical abuse. Some will wish to remove children voluntarily. This occasionally can be done but is frequently followed by the parents changing their minds or "hounding" the therapists with "are we ready today, tomorrow, next week." It is a better plan to involve the courts especially if the courts are positive and receptive.

One very distinct advantage of having a community consultation team is that the consultants on the team can be the individuals testifying in court, thereby limiting the primary physician to the role of reporting the nature of the physical findings rather than being an "expert" in child abuse or neglect. It takes a fair amount of skill and experience to testify in the adversary system of the court, and unless absolutely necessary, the primary physician should not be put into this predicament.

The courts lend a degree of authority in difficult cases, an authority which is very necessary if many of these families are going to be helped. When the courts must be involved, it requires the development of a dependency petition which should be written by the protective service worker, in cooperation with his or her legal consultant. The courts are asked frequently to accept responsibility for the care of a child in question for several months and periodically review the total situation to determine the progress that has been made in making this home safe for the child's return.

Display #10

The Diagnostic Process in Review And Where The Juvenile Courts Fit In


1. Case recognized in community (i.e., home, school, etc.)
2. Child taken to emergency room or doctor's office
3. Admission to hospital in most cases
4. Data gathering begins by team
4a. In hospital by medical component
4b. In community by Protective Services
5. Psychotic parent(s) found and referred for special care
6. CASE CONFERENCE Is the Home Safe?
7. Juvenile court
8. Treatment Plan and Follow-up Program

The Long-Term Treatment Phase

Even though most physicians may not be involved with the day-to-day aspect of the long-term (6 months to years) treatment phase, they must have a basic understanding of what can be accomplished during this period. The role of the general pediatrician or family physician during this phase is to support the total treatment plan and to provide follow through. Without an understanding of what is to be expected and how those helping the family go about this task, the physician can be of little help and support; he even may be counter productive.

The treatment programs that are effective in helping families who are abusive or neglectful of their children are based on our current understanding of the psycho-dynamics and "patho-physiology" of this problem. Most of the last decade was spent identifying the basic causes of child abuse and neglect. We are now in the period of initiating treatment programs developed from this theoretical framework. The next step of course, will be the initiating of early identification and preventive programs which are beginning to become feasible.

This discussion of the specific therapeutic programs which are helpful for the abused and/or neglected child and his family requires a review of some of the material that was covered at the beginning of this manual.

This material is presented in a different format to emphasize how the never-ending cycle of child abuse and neglect can be interrupted.

World of Abnormal Rearing (W.A.R.). Children who are abused and neglected find themselves reared in an unusual atmosphere, which we call the "World of Abnormal Rearing" (W.A.R.). W.A.R. children have experienced some very negative and detrimental happenings during their childhood, affecting them in many ways resulting in a variety of presentations to professionals, child abuse and/or neglect being only two of the many "spin-offs" from this abnormal rearing cycle. This point is discussed in more detail later.

The World of Abnormal Rearing will be reviewed in five separate sections moving counterclockwise around the W.A.R. cycle in the following order:

A. Conception—Pregnancy—Child
B. Unrealistic Expectations—Role Reversal—Compliance
C. Lack of Trust—Isolation—"I'm no Damn Good"
D. Selection of "friends" and mates
E. Childhood missed

Display #11

World of Abnormal Rearing

Conception—Pregnancy—Child

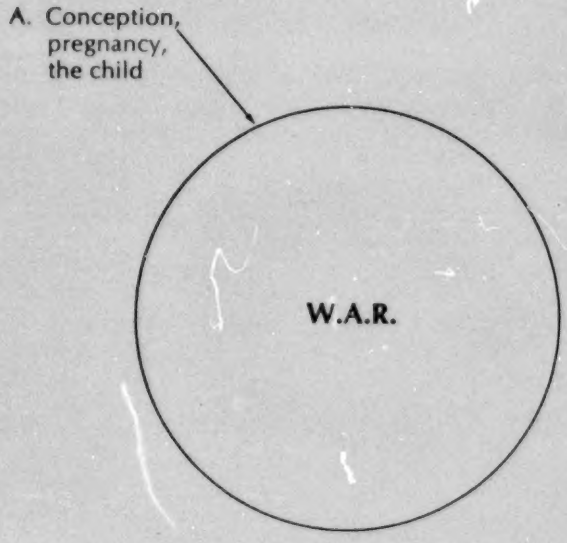
Most, but not all, conceptions lead to an on-going pregnancy. Although the advent of abortion interrupts a large number of pregnancies, it seems to interrupt less pregnancies of W.A.R. children. Girls who are reared in this unusual atmosphere have a strong desire to become pregnant. They often refuse the use of birth control and dismiss any thought of abortion. It is likely, therefore, that the decrease in number of children as a result of improved birth control methods and abortion will result in a *proportional increase* in the number of babies being born to girls reared in this World of Abnormal Rearing.

Conception, therefore, often leads to a wanted pregnancy in W.A.R. children, especially in the young age group. Unfortunately, the pregnancy is wanted for very selfish reasons, i.e., to resolve some special problem for the mother. The new baby is supposed to get her away from an unhappy experience in her home, or will keep her company or even take care of her and comfort her in her loneliness.

As the pregnancy comes to completion, the child may or may not have the capability of meeting the expectations that the parent(s) have developed throughout the W.A.R. years. Many young mothers who had every desire to get pregnant, with great expectations that the baby would resolve one of their many problems, find themselves even worse off than before. Their baby does not—or is not able to meet these needs.

Display #12

Treatment Programs For Section A Of The W.A.R. Cycle



Family planning and birth control measures must be pursued, even though frequently resisted by those reared in the W.A.R. A referral to family planning is *not* enough. Special counseling is necessary.

Abortion is rarely considered a viable alternative in many W.A.R. mothers since they *often* want to be pregnant.

Unrealistic Expectations, Role Reversal and Compliance

The World of Abnormal Rearing continues on in its never-ending cycle producing a child upon whom is placed very unrealistic expectations. These parents truly expect that the baby will resolve one or more of their many problems. When the baby is fortunate and doesn't have colic, sleeps at the same time as do the parents, doesn't make too many demands, reminds the parent of someone whom they like, has other very positive traits, is the right sex, etc., then things may go "reasonably well." On the other hand, when some or all of these factors or behaviors are reversed and the baby is not able to meet the expectations of the parents, then the child may well be in trouble. The stresses of caring for a small child are great enough for parents who are reared positively, but are almost impossible for the parents who have been brought up in the World of Abnormal Rearing.

There are some families who have such high expectations of children that there is no child who can meet them. These children are abused just because they are children. They find themselves in situations that are impossible to cope with, they become scapegoats and they can never do the right thing. They are constantly being chastised, belittled, neglected, and, often physically injured.

Children who are born into the World of Abnormal Rearing strive desperately to comply. Professionals often become very confused by this compliance since complying children may look like "good children" in that they are taking care of mother or dad and often may even try to care for the doctor or nurse. When one reflects on normal child developmental patterns, it becomes clear that the child in question is not acting his or her age, rather acting much older than one might expect. Although compliance is certainly something that all children and parents strive for to some degree, the extent of the compliance demanded by parents bringing their children up in the W.A.R. far exceeds the normal expectations.

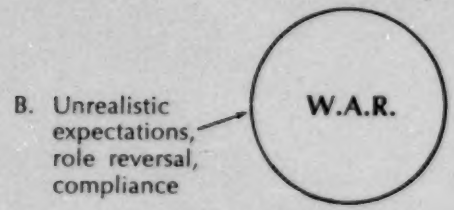
One of our parents told a public health nurse not long ago, "sometimes I think my baby's my mother." This is a very common feeling on the part of W.A.R. parents. They really expect the child to do for them that which they wished their mother had done when they were small. An-

other mother, who was having great difficulty in accepting her child as a child, said "I don't hit my child anymore since I joined Parents Anonymous, but I don't like the little bastard any better." She was very pleased that she was able to stop hitting, but someone had to help her see the child as a child and see him as someone she truly could like.

Many W.A.R. parents truly expect the child to take on the role of the parents and not act like a child. When a child must assume these roles then "Role Reversal" is painfully clear as you observe the child's behavior in the presence of the parent.

Display #13

Treatment Programs For Section B Of The W.A.R. Cycle



W.A.R. Parents must learn:

1. About normal child development
2. How to react to normal child behavior
3. What to expect of children
4. How to play with their children
5. General rearing and parenting skills

This can be done through:

1. Parenting courses—in schools, churches, doctors' offices, mental health centers, etc.
2. Group discussion sessions
3. Nursery school and grade school cooperatives
4. Some form of modeling of parenting

The W.A.R. Cycle, Section C

Lack of Trust, Isolation, and "I'm No Damn Good"

One of the basic skills that is not learned by children reared in this unusual manner is the ability to trust. Consider how a child learns to trust people; it stems from some very early life experiences. A little two year old runs to his mommy and cries, "I'm hurt. Up." Instead of being picked up and comforted, the mother says, "Oh, you stupid kid, you fell again," or "Don't bother me, I've got my own problems." The child learns very quickly that people are not around to help him when he has a problem. On the contrary, he learns that he must role reverse and take care of mother or father when *they* have a problem. If every time a child comes to someone for help he gets chastised, hit, or criticized, he will soon learn that people are not around to be helpful, rather, they hurt you. He best not depend on people if he has a problem.

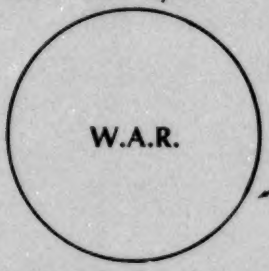
One 8-year-old girl had been abused most of her life. When asked, "What do you do when you have a problem, any kind of a problem?," she immediately answered by saying, "It's best if I deal with those myself." The concepts of distrust and lack of confidence in other people are learned quickly by W.A.R. children. They grow up to believe that they "damn well better deal with their own problems." One mother has yet to trust me enough to give me her phone number. To my knowledge, she has never given anybody her phone number.

Distrust on the part of the W.A.R. children leads to isolation. They find that they better handle their own problems and are not able to rely on people when a problem arises. In talking to these women and men about whom they relied on when they were in school, it is clear that they had no one. As our World of Abnormal Rearing cycle depicts, lack of trust and isolation leads to an inability to use other people positively, an inability to help other people and finally, a conviction that they are truly "no damn good." The self-image gradually but definitely degenerates. One 28-year-old mother was asked, "When was the last time you were helpful to someone?" After a great hesitation, she said, "I think when I was fourteen."

32

Display #14

Treatment Programs For Section C Of The W.A.R. Cycle



W.A.R. parents must:

1. Have the wall of isolation broken down
2. Learn how to trust others
3. Develop a better self image
4. Learn how to help others
5. Have access to others

This can be done through:

1. Providing them with a parent aide—a non-professional to establish a friendship
2. Joining a "lay" group—e.g., Parents Anonymous
3. Helping them get telephones and transportation
4. Finding suitable babysitters
5. Group therapy with professional guidance

THIS IS THE MOST SIGNIFICANT ASPECT OF THERAPY: TEACHING TRUST AND IMPROVING THE SELF-IMAGE WILL OFTEN TAKE MONTHS, BUT IT CAN BE DONE IN MOST CASES.

Selecting "Friends" and Mates

W.A.R. children, as they reach adolescence, find that their home and school experiences with friends and parents have been, for the most part, a disaster. They have major personal needs, but have never developed the skills to have these needs completely fulfilled. Selecting friends is not one of their special talents, which places their ability to select a mate in equal jeopardy. W.A.R. children find it most difficult to find someone with whom they can set up a close relationship, much less a marriage or living arrangement with someone who can meet many of their needs. A desire to leave the home and find someone who can help them supersedes their selectivity. The mates who are selected are soon found to be unhelpful and unsupporting. Shortly, the new marriage or living arrangment is often seen as unsatisfactory.

One of the major goals of this type of mate relationship is to have a baby. A baby, unlike a pregnancy of more normally reared individuals, is most often conceived for bizarre and unusual reasons. Almost invariably children who have been brought up in the W.A.R. get the impression that the baby is going to resolve one of their problems. As indicated earlier, the pregnancy is supposed to free them from their unhappy home, prove to their parents and themselves they can indeed be good parents, provide them with someone to keep them company, or to role reverse and begin to parent the parents. Once a baby is produced for these reasons, he is placed into an almost impossible situation. The cycle of the World of Abnormal Rearing now begins again with the new baby having to meet the same demands and expectations as did the parents when they were young. As one mother so sadly related, "I wanted all this time to have my baby, and when he was born he didn't do anything for me."

Display #15

Treatment Programs For Section D Of The W.A.R. Cycle

Major needs:

1. Strengthen inter-spouse relationship.
2. Teach spouse how to recognize when wife or husband is up tight.
3. Once recognized, what to do about it.
4. Skills on how to select friends and where they can be found.

This can be done by:

1. Marriage counselor, if counselor understands dynamics of the W.A.R.
2. Involving husband in **all** phases of treatment plan, especially in areas A, B, C and E.
3. Encourage maintaining marriage where possible, separation and/or divorce only if no other alternative.*

* This recommendation is made because the partners, particularly the mother, during the crisis need someone; if not their spouse, they often find one very similar to the mate they just left. One mother said, "Isn't it interesting that my boyfriend beats me just like my husband did?" (and so did her father).

Childhood Missed

Referring back to Display #11 (The W.A.R.), the phrase under this figure indicates that there is a significant gap in the developmental processes of W.A.R. children. They spend so much time trying to meet the needs of their parents that large segments of normal childhood must be relinguished. In not being allowed to experience many normal developmental happenings and required to spend much more time role reversing and complying, these children miss much of the most helpful learning processes necessary in becoming a parent, i.e., childhood. Having experienced childhood is a major pre-requisite to parenting. This includes, among other things, being treated as a child, the ability to develop a trusting relationship with others, learning the skills of establishing friendships, and feeling good about oneself. Many, if not all of these traits, are jeopardized in W.A.R. children.

W.A.R. children, when they become parents, truly expect their children to role reverse. For example, when mother's upset they need to be responsive. They relinguish the right to act like a child and experience normal child development, replacing it with those skills that they learn to help them meet the unrealistic expectations of their parents. The better they are at this, the more likely they will be accepted into the family. The more the child acts like a child, i.e., acts his age, the less likely he is to be accepted into this family. A 4 year old has trouble getting "permission" to have an occasional tantrum, explore the cupboards, scribble, say he's angry, etc.

Very frequently we find *siblings* of abused children who have learned the roles that they must play and they do it very well. On the other hand, we often find the *abused* child as someone who just cannot meet the expectations of the parents, and consequently finds himself verbally or physically attacked. One abusive mother, when asked "how did it go when you were little" said, "Just great. I got along very well with my parents." Confused, I finally asked, "How was it with your sister?" She immediately replied, "Oh, my father beat her severely."

The physician and others aware of child developmental sequences can pick up these developmental gaps as he observes children who are reared in this world. They often act more mature than their chronological age even though the

parents may see the child as being especially difficult. On the other hand, there are some W.A.R. children who give every appearance of being very difficult children to handle. Their rearing experiences have indicated to them that they are truly "bad kids" and if this continues unabated they will soon take on the life style that their parents have fostered.

Display #16

Treatment Programs For Section E Of The W.A.R. Cycle

E. CHILDHOOD MISSED

A. The abused and/or neglected child plus his/her siblings must be involved in treatment plan.
   1. Important to recall siblings also reared in W.A.R.
   2. Even though they may fare better physically.

B. The basic premise of children's treatment program is to teach children IT IS O.K. TO BE A CHILD.*
   1. Will need out of home experiences—nursery school, day care, grade school, special groups, play therapy, and even foster care at times.
   2. School personnel must understand the W.A.R. if they are to be helpful.

C. One of basic tenets of parents' therapy is to teach them IT IS O.K. TO HAVE A CHILD BE A CHILD.*

* Sometimes these achievements take significant time. In the judgment of those working with the parents, if the home is not safe for the child(ren), then the courts must be involved for temporary foster home placement.

Additional Points About Therapeutic Approaches

A few additional points should be made about therapeutic approaches for families who are abusive and/or neglectful.

Handling Crises

The crisis often precipitates, but is *not* the basic causative factor of the abusive act. Although treating the crisis is a major component of therapy, it is not an end in itself. Crisises fall into two major areas: Personal and Logistical. Every attempt must be made to assist the family in handling both aspects of these problems.

Personal counseling and advice needs to be readily available to the family at all hours of the day and night. Assessment as to their ability to handle personal crises must be made, and all those involved in the treatment program should be fully aware of potential problems.

Logistical crises must also be handled quickly. These include finding transportation, food, money, housing, clothing, etc. There is no point in trying to deal with many of the issues mentioned earlier if you have a hungry, ill and cold family. These crises are best handled by someone who knows community services very well.

As those involved with the family learn more about their needs, crises can be anticipated and thereby prevented. When this can occur, great progress has been made.

Handicraft Skills of Baby Care

Very frequently, parents who are abusive and/or neglectful find it extremely difficult to physically handle their babies. Some of these difficulties lie directly in the area of "handicraft." Things such as diapering, feeding, picking up, walking and playing with the child are skills not readily available to parents who have experienced the W.A.R. If, added to this, one or more of the parents is mentally retarded, additional difficulty develops.

Use of school and hospital training programs for parents with retardation and/or other problems in handling small children is of utmost importance. The Public Health Nurse can also be most helpful. She can serve in many of the other therapeutic roles discussed earlier as she begins to help the mother and father deal with small children.

Display #17

Additional Suggestions About Treatment

A. Crises must be handled:

1. W.A.R. parents rarely have learned the skills of solving their own crises.
2. It is hard to work on areas A through E if major crises still exist, e.g., no food, no transportation, husband without work, etc.
3. We must anticipate crises where possible, and prevent.
4. Crises are not the cause of abuse, rather the participating factor.

B. Handicraft skills for baby care are needed:

1. Many W.A.R. parents have never learned how to physically handle a baby.
2. Some abusive and neglectful parents are mentally retarded.
3. The skill of playing with children needs to be taught.*

* One W.A.R. mother said, "I can't wait till my baby is 2 years old so I can play with her."

Relatives

Inasmuch as the great majority of parents who are abusive and/or neglectful of their children are W.A.R. children themselves, there is little advantage to be gained by using the relatives as caretakers of the child in the long term treatment program. More often than not, the relatives have a negative influence on the parents and their incorporation in the treatment program should be very carefully planned if at all possible. Having a maternal grandmother care for the baby while the mother is learning some of the skills that she missed as a child may well be detrimental, since it is this very same grandmother who had difficulty in rearing the child's mother when she was small.

On occasion one can find a relative who is seen positively and can be incorporated into the treatment program. When one of the two parents has had more positive childhood experiences than the other, relatives on this side of the family might be useful. Every caution must be taken when relatives are considered as part of long-term treatment.

The Hard-Core or Incurable Family

It is estimated that about 10 percent of the families who are abusive to their children are psychotic or otherwise seriously ill psychiatrically. In addition to this, there is another 10 percent who, for a variety of reasons, cannot be reached. Even after extensive attempts to work with the family for a year, the result may yield little benefit.

Some of those who are hardest to reach, in addition to the severely psychiatrically ill, are those who believe that "God told me that it was alright to beat my baby." They produce biblical references with which they justify their interpretation of child rearing. Some States have, unfortunately, seen fit to give more legal rights to parents who use religious grounds to abuse or neglect their children than to parents who do not. This of course is an intolerable situation and must be changed.

Another group that is very difficult to deal with is the group with racial and/or cultural reasons that interfere with being helped. When these variables are added to the adverse affects of the W.A.R., occasionally the two are sufficient to prevent significant improvement by therapeutic efforts.

Like all diseases, there is a small group of individuals who are not helped with our current understanding of therapeutic approaches. When the point of no return has been reached, every effort must be made to continue to protect the child, and to suggest permanent removal by the courts. Unfortunately, State laws give very low priority to the rights of children when permanent removal is indicated.

Most parents, on the other hand, can be helped. Our goal at this point in our understanding should be to see a significant amount of improvement in approximately 70-75 percent of the families who have the problem of child abuse and/or neglect within 6-9 months after treatment begins.

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Use of relative in treatment plan:

1. Rarely are relatives helpful—after all, this is where the W.A.R. began.
2. Use great caution if someone suggests using grandmother as a foster mother for child.
3. Occasionally, parents or siblings of a "more positively reared" spouse may be useful.

Some families cannot be helped:

1. Although the psychotic or otherwise seriously psychiatrically ill parents may be helped personally, making them into reasonable parents is *often* most difficult.
2. Fanatics are very hard to help.
3. Some families just don't respond.
4. We should be able to help 70-75 percent with our present understanding and treatment programs.
5. As seen in many diseases, there is certain percentage of patients who are resistent to present therapeutic regimens.

Coordination of Services

Physicians should be readily aware that the social service system, i.e., Protective Services, has as its major function the coordination of *acute* care services. This may go on for two to four months, possibly six, but rarely any longer.* When one defines the roles of various individuals involved in treatment, it is clear that no group or agency sees as its responsibility the *long-term* coordination of services to families who have been abusive and/or neglectful. This is a serious gap in the services available to these ill families and is one that must be rectified in the very near future.

Little is gained by getting angry at departments of social services for not accepting the task of long-term coordination since it is not part of their current job description. Every attempt must be made to change this in every community throughout the country.

The Role of the Physician

The fact that our existing community services do not provide long-term therapy and follow-through is both surprising and alarming to physicians when they first realize the existence of the problem. And yet, we are used to this. It is not unusual for the physician to find that the implementation of treatment programs for any disease lags behind the understanding of how to treat a given illness. Consider the attempts to develop community and public health programs for tuberculosis, venereal disease, drug abuse, preventive immunizations for polio, etc. This problem is certainly present in the area of child abuse and neglect. Although the understanding as to how to provide treatment to large numbers of families is available, the actual implementation of these treatment programs has not occurred in most communities. Physicians must, as they have in other instances, be the advocates and prime movers for the development of such programs. We can no longer sit back and assume that these will occur. One of the most disastrous effects of the child abuse reporting law, although there have been many positive effects, is that it essentially says to the physician, "if you just report you have no further responsibility." This

* We recently completed a study of six protective service programs. Ninety percent of their interaction with the family was completed in one month.

is unalterably false and physicians cannot assume that treatment will take place once a report has been made. Every effort must be generated to develop multidisciplinary child abuse and neglect programs within the community in which the physician resides.

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The Physician As An Agent For Change

The cause of a very serious, life threatening disease is known and treatment programs which can be effective for some 70-75 percent of these families are available.

And Yet,

Our "Delivery of Services" system is not implementing what can be done.

* * * *

Physicians have the capability of influencing this system and making it move from single disciplines working in isolation to a trusting multidisciplinary community program.

And Yet,

Around the country the cry is, "Physicians just won't get involved!"

* * * *

All physicians who work with any family member need to know the basic causes and present therapeutic concepts.

And Yet,

It only takes *one* physician in a community to exhibit concern and commit himself or herself to seeing that change does occur.*

* The major reason the American Academy of Pediatrics initiated the development of the six self-instructional units for their members and others is to help professionals to become knowledgeable in the area of child abuse and neglect and serve as prime movers in developing community programs. Information about the self-instructional units should be addressed to the author.

Speculations

Call it fantasy, dreaming, knowledge of the field or what you will, the next ten years must see:

1. Child Protection diagnostic and consultation teams developed for every 300,000 population area.
2. Every hospital with 50 or more children's beds have an identifiable team which works closely with the community child abuse program.
3. Physicians (mostly pediatricians and/or family physicians) actively involved.
4. Long-term treatment and coordination programs a part of each community program.
5. Protective Services must become a multidisciplinary group rather than solely a short term, social work group as it is currently.
6. Early recognition and preventive programs developed.
7. These prevention programs must, for the most part, begin in the hospital during the perinatal period.
8. Schools becoming much more actively involved with parenting programs both for the students and their parents.
9. Family Courts expanding their services and be seen as helpful at a much earlier point in time.
10. Our knowledge about the W.A.R. broadened and this lead directly to a better understanding of Early Child Development, thereby helping families develop the skills necessary to begin wiping out the W.A.R.

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The most challenging task that remains is the early identification of W.A.R. children so that they can be provided the training they need. There is sufficient understanding to begin *preventive* service programs now, long before child abuse and neglect starts in the next generation. *Those children who will be helped the most are as yet unborn.*

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